NOTICE OF INDEPENDENT REVIEW DECISION

June 4, 2002

Respondent

Requestor

RE: Injured Worker:
MDR Tracking #: M2-02-0651-01
IRO Certificate #: 4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ____ health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ____ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 48 year old female presented to ____ on 02/22/02 for an injury that occurred on ___. She was employed at ____ at the time of the injury. The patient developed the onset of bilateral wrist pain, elbow pain, neck and arm pain. The patient was diagnosed with carpal tunnel syndrome and then underwent surgery on her right hand as well as injections in her right hand and elbow. In January of 2001, the patient underwent surgery on her left elbow. The patient suffers chronic pain in her neck, shoulders, both arms, hands and wrists. The treating chiropractor referred her for psychological testing and it was recommended that she undergo individual counseling with a Licensed Psychological Counselor (LPC) for 10 sessions.

Requested Service(s)

Individual counseling/psychotherapy

Decision

It is determined that individual counseling/psychotherapy is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The medical record documentation supports the medical necessity for the counseling/psychotherapy. The documentation describes the patient's chronic pain condition and her patient pain profile T-score suggests she is more depressed than the average pain patient. She is affected through her sleep and appetite disturbances and her concentration and decision making efforts are also hampered. She also has a stated history of psychological problems and the stress she has been through with her recent work injury requires evaluation and counseling.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

cc: David Martinez, Chief Medical Dispute Resolution, Medical Review Division, TWCC

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this _____ day of _____ 2002.

Signature of IRO Employee:

Printed Name of IRO Employee: